

**eHealth Initiative Analysis of
Senate Finance Language
(As of January 30, 2009)**

**Health Information Technology Provisions of
American Recovery and Reinvestment Act**

Please note that the following is only a summary of the legislative language.
The full text of the draft legislation can be accessed through the Senate Finance web site.

TITLE IV – HEALTH INFORMATION TECHNOLOGY

SUBTITLE A: PROMOTION OF HEALTH INFORMATION TECHNOLOGY

- I. **Definitions** (Section 3000)
- II. **Office of the National Coordinator for Health Information Technology** (Section 3001)
 - A. **Establishment.** Established within Department of Health and Human Services (HHS) an Office of the National Coordinator for Health Information Technology (referred to in this section as the ‘Office’). The Office shall be headed by a National Coordinator who shall be appointed by the Secretary and shall report directly to the Secretary.
 - B. **Purpose.** The National Coordinator shall perform the duties consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information
 - C. **Duties of the National Coordinator**
 - 1. **Standards.** Shall review and determine within 45 days of receipt, whether to endorse each standard, implementation specification, and certification criterion for the electronic exchange and use of health information that is recommended by the HIT Standards Committee for purposes of adoption by the Federal government.
 - 2. **Health IT Policy Coordination.** Shall coordinate health IT policy and programs of the Department with those of other relevant executive branch agencies with a goal of avoiding duplication of efforts. Shall be a leading member in the establishment and operations of the HIT Policy Committee and the HIT Standards Committee and shall serve as a liaison among those two Committees and the Federal Government.

3. **Strategic Plan.** Shall, in consultation with other appropriate Federal agencies (including the National Institute of Standards and Technology or NIST), update the Federal Health IT Strategic Plan to include specific objectives, milestones, and metrics with respect to:
 - The electronic exchange and use of health information and the enterprise integration of such information;
 - The utilization of an electronic health record (EHR) for each person in the U.S. by 2014; the incorporation of privacy and security protections for the electronic exchange of an individual's individually identifiable health information;
 - Ensuring security methods to ensure appropriate authorization and electronic authentication of health information and specifying technologies or methodologies for rendering health information unusable, unreadable, or indecipherable;
 - Specifying a framework for coordination and flow of recommendations and policies under this subtitle among the Secretary, the National Coordinator, the HIT Policy Committee, the HIT Standards Committee, and other health information exchanges and other relevant entities;
 - Methods to foster the public understanding of health IT; strategies to enhance the use of health IT in improving the quality of health care, reducing medical errors, reducing health disparities, improving public health, and improving the continuity of care among health care settings.

The strategic plan shall be updated through collaboration of public and private entities, and include measurable outcome goals, and the updated plan shall be re-published.

4. **Website.** The National Coordinator shall maintain and frequently update a website on which there is posted information on the work, schedules, reports, recommendations, and other information to ensure transparency in promotion of a nationwide health IT infrastructure.
5. **Certification.** The National Coordinator, in consultation with the Director of NIST, shall develop a program (either directly or by contract) for the voluntary certification of health IT as being in compliance with applicable certification criteria adopted under this section

6. Reports and Publications

- Not later than 12 months after enactment, the National Coordinator shall submit to the appropriate committees of jurisdiction of the House and the Senate a report on any additional funding or authority the Coordinator or the HIT Policy Committee or HIT Standards Committee requires to evaluate and develop standards, implementation specifications, and certification criteria, or to achieve full participation of stakeholders in the adoption of a

nationwide health IT infrastructure that allows for the electronic use and exchange of health information.

- The National Coordinator shall prepare a report that identifies lessons learned from major public and private health care systems in their implementation of health IT, including information on whether the technologies and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers.
- The National Coordinator shall assess and publish the impact of health information technology in communities with health disparities and in areas with a high proportion of individuals who are uninsured, underinsured, and medically underserved individuals (including urban and rural areas) and identify practices to increase the adoption of such technology by health care providers in such communities.
- The National Coordinator shall evaluate and publish evidence on the benefits and costs of the electronic use and exchange of health information and assess to whom these benefits and costs accrue.
- The National Coordinator shall estimate and publish resources required annually to reach the goal of utilization of an EHR for each person in the U.S. by 2014, including the required level of Federal funding, expectations for regional, State, and private investment, and the expected contributions by volunteers to activities for the utilization of such records.

7. **Assistance.** The National Coordinator may provide financial assistance to consumer advocacy groups and not-for-profit entities that work in the public interest for purposes of defraying the cost to such groups and entities to participate under, whether in whole or in part, the National Technology Transfer Act of 1995 (15 U.S.C. 272 note).

8. **Governance for Nationwide Health Information Network.** The National Coordinator shall establish a governance mechanism for the nationwide health information network.

D. **Detail of Federal Employees.** Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

E. **Chief Privacy Officer of the Office of the National Coordinator.** Not later than 12 months after enactment, the Secretary shall appoint a Chief Privacy Officer of the Office of the National Coordinator, whose duty it shall be to advise the National Coordinator on privacy, security, and data stewardship of electronic health information and to coordinate with other Federal agencies (and similar privacy

officers in such agencies), with State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health information.

III. **HIT Policy Committee** (Section 3002)

A. **Establishment.** There is established a HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health IT infrastructure, including implementation of the strategic plan.

B. **Duties.** Duties include the following:

1. **Recommendations on Health IT Infrastructure.** The HIT Policy Committee shall recommend a policy framework for the development and adoption of a nationwide health IT infrastructure that permits the electronic exchange and use of health information as is consistent with the strategic plan. The Committee shall update such recommendations and make new recommendations as appropriate.

2. **Specific Areas of Standard Development**

a. **General.** The HIT Policy Committee shall recommend the areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange and use of health information for purposes of adoption and shall recommend an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria among the areas so recommended. Such standards and implementation specifications shall include named standards, architectures, and software schemes for the authentication and security of individually identifiable health information and other information as needed to ensure the reproducible development of common solutions across disparate entities.

b. **Specific Areas of Standard Development.** The HIT Policy Committee shall make recommendations for at least the following areas:

- Technologies that protect the privacy of health information and promote security in a qualified HER, including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns, in accordance with applicable law, and for the use and disclosure of limited data sets of such information.
- A nationwide health IT infrastructure that allows for the electronic use and accurate exchange of health information.
- The utilization of a certified HER for each person in the United States by 2014.

- Technologies that as a part of a qualified EHR allow for an accounting of disclosures made by a covered entity for purposes of treatment, payment, and health care operations.
- The use of certified EHRs to improve the quality of health care, such as by promoting the coordination of health care and improving continuity of health care among healthcare providers, by reducing medical errors, by improving population health, and by advancing research and education.

c. **Other Areas for Consideration.** In making recommendations, the HIT Policy Committee may consider the following additional areas:

- The appropriate uses of a nationwide health information infrastructure, including for purposes of the collection of quality data and public reporting; biosurveillance and public health; medical and clinical research; and drug safety.
- Self-service technologies that facilitate the use and exchange of patient information and reduce wait times.
- Telemedicine technologies, in order to reduce travel requirements for patients in remote areas.
- Technologies that facilitate home health care and the monitoring of patients recuperating at home.
- Technologies that help reduce medical errors.
- Technologies that facilitate the continuity of care among health settings.
- Technologies that meet the needs of diverse populations.
- Any other technology that the HIT Policy Committee finds to be among the technologies with the greatest potential to improve the quality and efficiency of health care.

d. **Forum.** HIT Policy Committee shall serve as a forum for broad stakeholder input with specific expertise in policies relating to the matters described in paragraphs above.

C. Membership and Operations

1. **General.** The National Coordinator shall provide leadership in the establishment and operations of the HIT Policy Committee.
2. **Membership.** The membership of the HIT Policy Committee shall at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.

3. **Consideration.** The National Coordinator shall ensure that the relevant recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies.
4. **Application of FACA.** The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the HIT Policy Committee.
5. **Publication.** The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all policy recommendations made by the HIT Policy Committee under this section.

IV. **HIT Standards Committee** (Section 3003)

A. **Establishment.** There is established a committee to be known as the HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of adoption, consistent with the implementation of the strategic plan and beginning with the areas listed below in accordance with policies developed by the HIT Policy Committee.

B. Duties

1. **Standards Development.**

- a. **General.** The HIT Standards Committee shall recommend to the National Coordinator standards, implementation specifications, and certification criteria described in subsection (a) that have been developed, harmonized, or recognized by the HIT Standards Committee. The HIT Standards Committee shall update such recommendations and make new recommendations as appropriate, including in response to a notification sent. Such recommendations shall be consistent with the latest recommendations made by the HIT Policy Committee.
- b. **Pilot Testing of Standards and Implementation Specifications.** In the development, harmonization, or recognition of standards and implementation specifications, the HIT Standards Committee shall, as appropriate, provide for the testing of such standards and specifications.
- c. **Consistency.** The standards, implementation specifications, and certification criteria recommended under this subsection shall be consistent with the standards for information transactions and data elements adopted pursuant to section 1173 of the Social Security Act.

2. **Forum.** The HIT Standards Committee shall serve as a forum for the participation of a broad range of stakeholders to provide input on the development,

harmonization, and recognition of standards, implementation specifications, and certification criteria necessary for the development and adoption of a nationwide health IT that allows for the electronic use and exchange of health information.

3. **Schedule.** Not later than 90 days after the date of the enactment of this title, the HIT Standards Committee shall develop a schedule for the assessment of policy recommendations developed by the HIT Policy Committee. The HIT Standards Committee shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register.
4. **Public Input.** The HIT Standards Committee shall conduct open public meetings and develop a process to allow for public comment on the schedule described and recommendations described in this subsection. Under such process comments shall be submitted in a timely manner after the date of publication of a recommendation under this subsection.

C. Membership and Operations

1. **General.** The National Coordinator shall provide leadership in the establishment and operations of the HIT Standards Committee.
 2. **Membership.** The membership of the HIT Standards Committee shall at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.
 3. **Consideration.** The National Coordinator shall ensure that the relevant recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of standards.
 4. **Assistance.** For the purposes of carrying out this section, the Secretary may provide or ensure that financial assistance is provided by the HIT Standards Committee to defray in whole or in part any membership fees or dues charged by such Committee to those consumer advocacy groups and not for profit entities that work in the public interest as a part of their mission.
- D. **Application of FACA.** The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the HIT Standards Committee.
- E. **Publication.** The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all recommendations made by the HIT Standards Committee under this section.

V. **Process for Adoption of Endorsed Recommendations; Adoption of Initial Set of Standards; Implementation Specifications; and Certification Criteria** (Section 3004)

A. **Process for Adoption of Endorsed Recommendations.**

1. **Review of Endorsed Standards, Implementation Specifications, and Certification Criteria.** Not later than 90 days after the date of receipt of standards, implementation specifications, or certification criteria endorsed by the Secretary, in consultation with representatives of other relevant Federal agencies, shall jointly review such standards, implementation specifications, or certification criteria and shall determine whether or not to propose adoption of such standards, implementation specifications, or certification
2. **Determination to Adopt Standards, Implementation Specifications, and Certification Criteria.** If the Secretary determines (A) to propose adoption of any grouping of such standards, implementation specifications, or certification criteria, the Secretary shall, by regulation, determine whether or not to adopt such grouping of standards, implementation specifications, or certification criteria; or (B) not to propose adoption of any grouping of standards, implementation specifications, or certification criteria, the Secretary shall notify the National Coordinator and the HIT Standards Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation.
3. **Publication.** The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under paragraph.

B. **Adoption of Initial Set of Standards; Implementation Specifications; and Certification Criteria.**

1. **General.** Not later than December 31, 2009, the Secretary shall, through the rulemaking process described, adopt an initial set of standards, implementation specifications, and certification criteria for the areas required for consideration.
2. **Application of Current Standards, Implementation Specifications, and Certification Criteria.** The standards, implementation specifications, and certification criteria adopted before the date of the enactment of this title through the process existing through the Office of the National Coordinator for Health Information Technology may be applied towards meeting the requirement.

VI. **Transitions** (Section 3005)

- A. **ONCHIT.** To the extent consistent with section 3001, all functions, personnel, assets, liabilities, and administrative actions applicable to the National Coordinator for Health Information Technology appointed under Executive Order 13335 or the Office of such National Coordinator on the date before the date of the enactment of this title shall be

transferred to the National Coordinator appointed under section 3001(a) and the Office of such National Coordinator as of the date of the enactment of this title.

B. AHIC.

1. To the extent consistent with sections 3002 and 3003, all functions, personnel, assets, and liabilities applicable to the AHIC Successor, Inc. doing business as the National eHealth Collaborative as of the day before the date of the enactment of this title shall be transferred to the HIT Policy Committee or the HIT Standards Committee, established under section 3002(a) or 3003(a), as appropriate, as of the date of the enactment of this title.
2. In carrying out section 3003(b)(1)(A), until recommendations are made by the HIT Policy Committee, recommendations of the HIT Standards Committee shall be consistent with the most recent recommendations made by such AHIC Successor, Inc.

C. Rules of Construction.

1. ONCHIT.—Nothing in section 3001 or subsection (a) shall be construed as requiring the creation of a new entity to the extent that the Office of the National Coordinator for Health Information Technology established pursuant to Executive Order 13335 is consistent with the provisions of section 3001.
2. AHIC.—Nothing in sections 3002 or 3003 or subsection (b) shall be construed as prohibiting the AHIC Successor, Inc. doing business as the National eHealth Collaborative from modifying its charter, duties, membership, and any other structure or function required to be consistent with section 3002 and 3003 in a manner that would permit the Secretary to choose to recognize such Community as the HIT Policy Committee or the HIT Standards Committee.

SUBTITLE B: Incentives for the Use of Health Information Technology

PART I: MEDICARE PROGRAM

I. Incentives for Eligible Professionals (Section 4201)

A. Incentive Payments

1. **In General.** Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year, if the eligible professional is a meaningful EHR user for the reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year. No incentive payments will be made after 2015.

2. Limitations on Amounts of Incentive Payments

- a. **In General.** In no case shall the amount of the incentive payment provided exceed the applicable amount specified with respect to such eligible professional and such year.
- b. **Amount.** The applicable amount specified for an eligible professional is as follows:
- For the first payment year for such professional, \$15,000 (or if the first payment year for such eligible professional is 2011 or 2012, \$18,000)
 - For the second payment year for such professional, \$12,000.
 - For the third payment year for such professional, \$8,000.
 - For the fourth payment year for such professional, \$4,000.
 - For the fifth payment year for such professional, \$2,000.
 - For any succeeding payment year for such professional, \$0.
- c. **Phase Down for Eligible Professionals First Adopting EHR In 2014.** If the first payment year for an eligible professional is 2014, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause for such payment year for an eligible professional whose first payment year is 2013.
- d. **Increase for Certain Rural Eligible Professionals.** In the case of an eligible professional who predominantly furnishes services under this part in a rural area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, the

amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 25 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection.

- e. **No Incentive If First Adopting After 2014.** If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be \$0.

3. Non-Application to Hospital-Based Eligible Professionals

- a. **In General.** No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.
- b. **Hospital-Based Eligible Professional.** For purposes of clause the term ‘hospital-based eligible professional’ means, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including computer equipment, of the hospital.

4. Payment

- a. **Form of Payment.** The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.
- b. **Coordination of Application of Limitation for Professionals in Different Practices.** In the case of an eligible professional furnishing covered professional services in more than one practice, the Secretary shall establish rules to coordinate the incentive payments.
- c. **Coordination with Medicaid.** The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State Governments to demonstrate meaningful use of certified EHR technology.

5. Payment Year Defined

- a. **General.** For purposes of this subsection, the term ‘payment year’ means a year beginning with 2011.
- b. **First, Second, etc. Payment. Year.** The term ‘first payment year’ means, the first year for which an incentive payment is made for such services under this

subsection. The terms ‘second payment year’, ‘third payment year’, ‘fourth payment year’, and ‘fifth payment year’ mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

B. Meaningful EHR User

1. **General.** An eligible professional shall be treated as a meaningful EHR user for a reporting period for a payment year if each of the following requirements is met:
 - a. **Meaningful Use of Certified EHR Technology.** The eligible professional demonstrates to the satisfaction of the Secretary that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.
 - b. **Information Exchange.** The eligible professional demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.
 - c. **Reporting on Measures Using EHR.** Using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary.

The Secretary may provide for the use of alternative means for meeting the requirements of clauses in the case of an eligible professional furnishing covered professional services in a group practice. The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

2. Reporting on Measures

- a. **Selection.** The Secretary shall select measures but only consistent with the following:
 - The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary.
 - Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

- b. **Limitation.** The Secretary may not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.
- c. **Coordination of Reporting of Information.** In selecting such measures, and in establishing the form and manner for reporting measures, the Secretary shall seek to avoid redundant or duplicative reporting otherwise required.

3. **Demonstration of Meaningful Use of Certified EHR Technology and Information Exchange**

- a. **General.** A professional may satisfy the demonstration requirement through means specified by the Secretary, which may include—
 - an attestation;
 - the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);
 - a survey response;
 - reporting under subparagraph (A)(iii); and
 - other means specified by the Secretary.
- b. **Use of Part D Data.** The Secretary may use data regarding drug claims submitted for purposes of section.

C. **Application**

1. **Physician Reporting System Rules.**
2. **Coordination With Other Payments.**
3. **Limitations on Review.** There shall be no administrative or judicial review under certain sections, or otherwise of the determination of any incentive payment under this subsection and the payment adjustment under certain subsections, including the determination of a meaningful EHR user, the limitation, and the exception.
4. **Posting on Website.** The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments.
5. **Certified EHR Technology Defined.** For purposes of this section, the term ‘certified EHR technology’ means a qualified electronic health record that is certified as meeting standards adopted under certain section that are applicable to the type of record involved (as determined by the Secretary, such as an

ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

6. Definitions.

D. Incentives Payment Adjustment

1. Incentives for Meaningful Use of Certified EHR Technology

a. **General.** With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the eligible professional is not a meaningful EHR user for a reporting period for the year, the fee schedule amount for such services furnished by such professional during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection

- for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) for 2014, 98 percent);
- for 2016, 98 percent; and
- for 2017 and each subsequent year, 97 percent.

b. **Authority to Decrease Applicable Percentage for 2018 and Subsequent Years.** For 2018 and each subsequent year, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case shall the applicable percent be less than 95 percent.

2. **Significant Hardship Exception.** The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

3. Application of Physician Reporting Rules

4. **Non-Application to Hospital Based Eligible Professionals.** No payment adjustment may be made in the case of hospital-based eligible professionals.

5. Definitions

E. Application to Certain MA-Affiliated Eligible Professionals

1. **General.** In the case of a qualifying MA organization, the provisions shall apply with respect to eligible professionals described who the organization attests to be meaningful EHR users.
2. **Eligible Professional Described.** With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional who—
 - a. is employed by the organization, or is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's patient care services to enrollees of such organization; and
 - b. furnishes at least 75 percent of the professional services of the eligible professional to enrollees of the organization; and
 - c. furnishes, on average, at least 20 hours per week of patient care services.
3. **Eligible Professional Incentive Payments**
 - a. **General.**
 - b. **Avoiding Duplication of Payments.**
 - c. **Fixed Schedule for Application of Limitation on Incentive Payments for All Eligible Professionals**
 - d. **Cap for Economies of Scale**
4. **Payment Adjustment**
5. **Qualifying MA Organization Defined.** The term 'qualifying MA organization' means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act).
6. **Meaningful EHR User Attestation.** A qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary identifying—
 - a. whether each eligible professional described in paragraph with respect to such organization is a meaningful EHR user for a year specified by the Secretary; and
 - b. whether each eligible hospital described with respect to such organization, is a meaningful EHR user for an applicable period specified by the Secretary.
7. **Posting on the Website**

F. Conforming Amendments

G. Conforming Amendments to e-Prescribing

H. Providing Assistance to Eligible Professionals and Certain Hospitals

1. **General.** The Secretary of Health and Human Services shall provide assistance to eligible professionals, Medicaid providers, and eligible hospitals located in rural or other medically underserved areas to successfully choose, implement, and use certified EHR technology.
2. **USE OF ENTITIES WITH EXPERTISE.** To the extent practicable, the Secretary shall provide such assistance through entities that have expertise in the choice, implementation, and use of such certified EHR technology.

II. Incentives for Hospitals (Section 4202)

A. Incentive Payment

1. **General.** Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year, if the eligible hospital is a meaningful EHR user for the reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust Fund established under section 1817, in an amount equal to the applicable amount specified below for the hospital for such payment year.

2. Payment Amount

- a. **General.** Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following:
 - **Initial Amount.** The sum of the base amount; plus the discharge related amount for a 12-month period selected by the Secretary with respect to such payment year.
 - **Medicare Share.** The Medicare share for the hospital for a period selected by the Secretary with respect to such payment year.
 - **Transition Factor.** The transition factor for the hospital for the payment year.
- b. **Base Amount.** The base amount specified in this subparagraph is \$2,000,000.
- c. **Discharge Related Amount.** The discharge related amount for a 12-month period selected by the Secretary shall be determined as the sum of the amount, based upon total discharges for the period, for each discharge up to the 23,000th discharge as follows:

- For the 1,150th through the 9,200th discharge, \$200.
- For the 9,201st through the 13,800th discharge, 50 percent of the amount specified
- For the 13,801st through the 23,000th discharge, 30 percent of the amount specified

d. **Medicare Share.** The Medicare share specified under this subparagraph for a hospital for a period selected by the Secretary for a payment year is equal to the fraction—

- The numerator of which is the sum (for such period and with respect to the hospital) of the number of inpatient-bed-days which are attributable to individuals with respect to whom payment may be made under part A; and the number of inpatient bed-days which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and
- The denominator of which is the product of the total number of inpatient-bed-days with respect to the hospital during such period; and the total amount of the hospital's charges during such period, not including any charges that are attributable to charity care, divided by the total amount of the hospital's charges during such period.

e. **Transition Factor Specified.** Subject to above clause, the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

- For the first payment year for such hospital, 1.
- For the second payment year for such hospital, $\frac{3}{4}$.
- For the third payment year for such hospital, $\frac{1}{2}$.
- For the fourth payment year for such hospital, $\frac{1}{4}$.
- For any succeeding payment year for such hospital, 0.

Phase Down for Eligible Hospitals First Adopting EHRs After 2013. If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

f. **Form of Payment.** The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

g. **Payment Year Defined**

- **General.** For purposes of this subsection, the term ‘payment year’ means a fiscal year beginning with fiscal year 2011.
- **First, Second, etc. Payment Year.** The term ‘first payment year’ means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms ‘second payment year’, ‘third payment year’, and ‘fourth payment year’ mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

3. Meaningful EHR User

a. **In General.** An eligible hospital shall be treated as a meaningful EHR user for a reporting period for a payment year if the following requirements are met:

- **Meaningful Use of Certified EHR Technology.** The eligible hospital demonstrates to the satisfaction of the Secretary, that during such period the hospital is using certified EHR technology in a meaningful manner.
- **Information Exchange.** The eligible hospital demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.
- **Reporting of Measures Using EHR.** Using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary. The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

b. Reporting on Measures.

- **Selection.** The Secretary shall select measures but only consistent with the following:
 - The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection or that have been endorsed by the entity with a contract with the Secretary.
 - Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection) being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

- **Limitations.** The Secretary may not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.
- **Coordination of Reporting of Information.** In selecting such measures, and in establishing the form and manner for reporting measures, the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required.

c. Demonstration of Meaningful Use of Certified EHR Technology and Information Exchange

- **General.** A hospital may satisfy the demonstration requirement through means specified by the Secretary, which may include—
 - An attestation;
 - The submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);
 - A survey response;
 - Reporting under subparagraph and
 - Other means specified by the Secretary.
- **Use of Part D Data.** The Secretary may use data regarding drug claims.

4. Application

- **Limitations on Review.** There shall be no administrative or judicial review or otherwise of the determination of any incentive payment under this subsection and the payment adjustment, including the determination of a meaningful EHR user, determination of measures applicable to services furnished by eligible hospitals under this subsection, and the exception under subsection.
- **Posting on Website.** The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that a hospital has the opportunity to review the other relevant data that are to be made public with respect to the hospital prior to such data being made public.

5. Certified EHR Technology Defined

6. Definitions

B. Incentive Market Basket Adjustment. Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

1. in clause (viii)(I), by inserting “(or, beginning with fiscal year 2016, by one-quarter)” after “2.0 percentage points”; and
2. by adding at the end the following new clause:
 - a. For purposes of clause for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital that is not a meaningful EHR user for the reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause for such fiscal year shall be reduced by 33 1/3 percent for fiscal year 2015, 66 2/3 percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause for a subsequent fiscal year. “
 - b. The Secretary may, on a case-by-case basis, exempt a subsection (d) hospital from the application of subclause with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a hospital be granted an exemption under this subclause for more than 5 years.
 - c. For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1814(b)(3) shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence.
 - d. For purposes of this clause, the term ‘reporting period’ means, with respect to a fiscal year, any period (or periods), with respect to the fiscal year, as specified by the Secretary.’’.

3. Critical Access Hospitals

C. Application to Certain MA-Affiliated Eligible Hospitals

1. **Application.** In the case of a qualifying MA organization, the provisions of sections shall apply with respect to eligible hospitals of the organization which the organization attests to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments shall be made to and payment adjustments shall apply to such qualifying organizations.
2. **Eligible Hospital Described.** With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

3. Eligible Hospital Incentive Payments

- a. **In General.** Instead of the additional payment amount there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part.

b. Avoiding Duplication of Payments.

4. Payment Adjustment.

a. Medicare Hospital Expenditure Proportion

b. Application of Payment Adjustment

5. Posting on Website

D. Conforming Amendments

III. Premium Hold Harmless and Implementation Funding (Section 4203)

A. Premium Hold Harmless

1. **In General..**
2. **Payment.**

B. Implementation Funding. In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of HHS for the Center for Medicare & Medicaid Services Program Management Account, \$100,000,000 for each of fiscal years 2009 through 2015 and \$45,000,000 for each succeeding fiscal year through fiscal year 2018, which shall be available for

purposes of carrying out the provisions of (and amendments made by) this part. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

IV. Non-Application of Phased-Out Indirect Medical Education (IME) Adjustment Factor for Fiscal Year 2009 (Section 4204)

V. Study on Application of EHR Payment Incentives for Providers Not Receiving Other Incentive Payments (Section 4205)

A. Study

1. **In General.** The Secretary of HHS shall conduct a study to determine the extent to which and manner in which payment incentives and other funding for purposes of implementing and using qualified health information technology should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under title XVIII or XIX of the Social Security Act, or otherwise, for such purposes.

2. **Details of Study.** Such study shall include an examination of—

- a. the adoption rates of qualified health IT by such health care providers;
- b. the clinical utility of such technology by such health care providers;
- c. whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology;
- d. the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act, title XVIII or XIX of the Social Security Act, or otherwise;
- e. the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and
- f. any other issues the Secretary deems to be appropriate.

B. Report. Not later than June 30, 2010, the Secretary shall submit to Congress a report on the findings and conclusions of the study conducted.

VI. Study on Availability of Open Source HIT Systems (Section 4206)

A. Study

1. **In General.** The Secretary of HHS shall, in consultation with other relevant federal agencies, conduct a study on the current availability of open source HIT systems to Federal safety net providers; the total cost of ownership of such systems in comparison to the cost of proprietary commercial products available; the ability of such systems to respond to the need of, and be applied to, various populations; and the capacity of such systems to facilitate interoperability.

2. **Considerations.** The Secretary shall take into account the circumstances of smaller health care providers, health care providers located in rural or other medically underserved areas, and safety net providers that deliver a significant level of health care to uninsured individuals, Medicaid beneficiaries, SCHIP beneficiaries, and other vulnerable individuals.

B. Report

1. Not later than October 1, 2010, the Secretary of Health and Human Services shall submit to Congress a report on the findings and the conclusions of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—MEDICAID FUNDING

I. Medicaid Provider EHR Adoption and Operation Payments; Implementation Funding (Section 4221)

A. **In General.** Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

1. in subsection (a)(3)—
 - a. by striking “and” at the end of subparagraph (D);
 - b. by striking “plus” at the end of subparagraph (E) and inserting “and”; and (C) by adding at the end the following new subparagraph: “(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) by Medicaid providers described in subsection (t)(1); and “(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus”; and
2. by inserting after subsection (s) the following new subsection:
 - a. by inserting after subsection (s) the following new subsection: “(t)(1) For purposes of subsection (a)(3)(F), the payments for certified EHR technology (and support services including maintenance that is for, or is necessary for the operation of, such technology) by Medicaid providers described in this paragraph are payments made by the State in accordance with this subsection of the applicable percent of the net allowable costs of Medicaid providers for such technology (and support services).
 - b. For purposes of subparagraph (a), the term ‘applicable percent’ means—“(i) in the case of a Medicaid provider described in paragraph (2)(A), 85 percent; “(ii) in the case of a Medicaid provider described in clause (i) or (ii) of paragraph (2)(B), 100 percent; and “(iii) in the case of a Medicaid provider described in clause (iii) of paragraph (2)(B), a percent specified by the Secretary, but not less than 85 percent.
 - c. In this subsection and subsection (a)(3)(F), the term ‘Medicaid provider’ means—
 - an eligible professional who is not hospital-based and has at least 30 percent of the professional’s patient volume attributable to individuals who are receiving medical assistance under this title; and

- (i) a children’s hospital, (ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital’s patient volume attributable to individuals who are receiving medical assistance under this title, or (iii) a Federally-qualified health center or rural health clinic that has at least 30 percent of the center’s or clinic’s patient volume (as estimated in accordance with standards established by the Secretary) attributable to individuals who are receiving medical assistance under this title.

A professional shall not qualify as a Medicaid provider under this subsection unless the professional has waived, in a manner specified by the Secretary, any right to payment under section 1848(o) with respect to the adoption or support of certified EHR technology by the professional. In applying clauses (ii) and (iii) of subparagraph (B), the standards established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan

3. in this subsection and subsection (a)(3)(F):

- a. The term ‘certified EHR technology’ means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to such Act as meeting standards adopted under such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory EHR for office-based physicians or an inpatient hospital EHR for hospitals).
- b. The term ‘eligible professional’ means a physician as defined in paragraphs (1) and (2) of section 1861(r), and includes a nurse mid-wife and a nurse practitioner.
- c. The term ‘hospital-based’ means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual’s professional services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including computer equipment, of the hospital.

4. the term “allowable costs” means, with respect to

- a. The term ‘allowable costs’ means, with respect to certified EHR technology of a Medicaid provider, costs of such technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) as determined by the Secretary to be reasonable.
- b. The term ‘net allowable costs’ means allowable costs reduced by any payment that is made to the provider involved from any other source that is directly attributable to payment for certified EHR technology or services described in subparagraph.

- c. In no case shall—
- the aggregate allowable costs under this subsection (covering one or more years) with respect to a Medicaid provider for purchase and initial implementation of certified EHR technology exceed \$25,000 or include costs over a period of longer than 5 years;
 - for costs not described in clause relating to the operation, maintenance, or use of certified EHR technology, the annual allowable costs under this subsection with respect to such a Medicaid provider for costs not described in clause for any year exceed \$10,000;
 - payment described for costs described be made with respect to such a Medicaid provider over a period of more than 5 years;
 - the aggregate allowable costs under this subsection with respect to such a Medicaid provider for all costs exceed \$75,000; or
 - the allowable costs, whether for purchase and initial implementation, maintenance, or otherwise, for a Medicaid provider exceed such aggregate or annual limitation as the Secretary shall establish, based on an amount determined by the Secretary as being adequate to adopt and maintain certified EHR technology).
5. Payments described are not in accordance with subsection unless the following requirements are met
- a. The State provides assurances satisfactory to the Secretary that amounts received with respect to costs of a Medicaid provider are paid directly to such provider without any deduction or rebate.
 - b. Such Medicaid provider is responsible for payment of the costs described in such paragraph that are not provided under this title.
 - c. With respect to payments to such Medicaid provider for costs other than costs related to the initial adoption of certified EHR technology, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied.
 - d. To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.
6. In no case
- a. In no case shall the payments described in paragraph (1), with respect to a hospital, exceed in the aggregate the product of (i) the overall hospital HIT amount for the hospital computed under subparagraph (B); and (ii) the Medicaid share for such hospital computed. ‘
 - b. For purposes of this paragraph, the overall hospital HIT amount, with respect to a hospital, is the sum of the applicable amounts specified in section for such hospital for the first 4 payment years determined as if the Medicare share

specified in clause of such section were 1. The Secretary shall publish in the Federal Register the overall hospital HIT amount for each hospital eligible for payments under this subsection. In computing amounts under clause (ii) for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at an annual rate of 2 percent per year.

- c. The Medicaid share computed under this subparagraph, for a hospital for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1886(n)(2)(D) for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days which are attributable to individuals who are receiving medical assistance under this title and who are not described in section 1886(n)(2)(D)(i). In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).
7. With respect to health care providers other than hospitals, the Secretary shall ensure coordination of the different programs for payment of such health care providers for adoption or use of health information technology (including certified EHR technology), as well as payments for such health care providers provided under this title or title XVIII, to assure no duplication of funding.
 8. In carrying out paragraph the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State Governments to demonstrate meaningful use of certified EHR technology under this title and title XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under title XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.
 9. In order to be provided Federal financial participation under subsection a State must demonstrate to the satisfaction of the Secretary, that the State—
 - a. is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;
 - b. conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and
 - c. be pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

10. The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments under paragraph (1).”.

- B. Implementation Funding.** In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account, \$40,000,000 for each of fiscal years 2009 through 2015 and \$20,000,000 for each succeeding fiscal year through fiscal year 2018, which shall be available for purposes of carrying out the provisions of (and the amendments made by) this part. Amounts appropriated under this subsection for a fiscal year shall be available until expended.
- C. HHS Report on Implementation of Detailed Process to Assure No Duplication of Funding.** Not later than July 1, 2012, the Secretary shall submit to Congress a report on the establishment and implementation of the detailed process under section 1903(t)(7) of the Social Security Act, as added by subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.